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tasis was 10.9 ± 8.9 months. The percentages of patients receiving at least one of these therapies increased from 10.5% in 2005 to 74% in 2008. Sunitinib use showed consistent increase from 0% in 2005 to 50% in 2008. Sorafenib with zero use in 2005 increased to 25% in 2006 but decreased thereafter to 11.7% in 2008. Interferon-alpha (range: 5–8%) and bevacizumab (range: 2–4%) use remained relatively stable during the observation period, whereas interleukin-2 and temsirolimus was used rarely (≤1%) and everolimus not used at all. **CONCLUSIONS:** Pharmacologic agents were increasingly used to treat mRCC patients in recent years. Targeted therapies have become the main modality of treatment, with sunitinib accounting for most of the growth.

PCN153

TREATMENT PATTERNS OF MEXICAN ONCOLOGISTS IN FIVE DIFFERENT MALIGNANCIES: A SURVEY

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OBJECTIVES: There is no evidence about real medical practice in oncology in Mexico. The objective of this study was to explore current medical practices of Mexican oncologists in the management of five malignancies: breast, non-small cell lung (NSCL), colon, rectum and kidney cancer. **METHODS:** A specific instrument for these malignancies was designed, validated and applied to Mexican oncologists. Information requested reflects stage-specific treatment and disease management, including surgery and drugs uses, as well as frequency of prescription, discontinuation and factors that determines them in public and private health care institutions, between January-April 2009. **RESULTS:** 30 oncologists were included: 63.3% from Instituto Mexicano del Seguro Social and 20.0% from Instituto Nacional de Cancerología. 73.3% of all oncologists have public and private practices. Tamoxiphen (adjuvant hormonoterapy) and 5-fluoroacil/epirubicin/cyclophosphamide (adjuvant, neoadjuvant and palliative chemotherapy) are the most frequently drug schemes used in breast cancer, with no differences between public and private practices($p < 0.05$). At least 85.0% of NSCL cancer cases are diagnosed in IIIA and IV stages; combination chemotherapy (platinum/etoposide) is highly prescribed in NSCL cancer patients undergoing radiotherapy or non-resectable disease. Colon cancer is diagnosed in stages III(58.0%) and IV (14.0%); 20.0% of colon cancer patients undergoes surgery (left or right hemicolectomy). Drug availability and medical guidelines recommendations drive prescription to treat colon cancer. Surgery in rectum cancer is applied at stages IIB, IIIA and IIIB (17.6%, 20.0% and 16.9%, respectively). Rectum cancer presents as non-resectable disease in 60.0% of cases in stage IV. Drugs used to treat metastatic renal cells cancer are interferon-α (80.0%) and sunitinib(19.0%), prescription is driven by drug availability and efficacy, respectively. Discontinuation rate of interferon-α due adverse event was 90.0%. **CONCLUSIONS:** Knowledge of oncology current medical practice provides a basis for evaluation, as well as supports decision making process and the generation of new strategies for policy makers.

PCN154

COLORECTAL CANCER HOSPITAL ADMISSIONS IN WEST VIRGINIA FROM 2003 TO 2007

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OBJECTIVES: Colorectal cancer (CRC) is the third most common form of cancer in men and women in West Virginia. Hospitalization followed by surgical resection is the standard curative treatment. The aim of this study is to examine colorectal cancer hospitalizations and common comorbidities and evaluate associated outcomes during 2003–2007 in West Virginia. **METHODS:** Data from the Healthcare Cost and Utilization Project (HCUP), State Inpatient Database were investigated. Comorbidities were identified using comorbidity software provided by HCUP. Descriptive statistics for hospitalizations with a primary or secondary diagnosis of CRC were tabulated. Multivariate regressions were used to compare for differences in the outcomes including length of stay, total charges, and in-hospital deaths. **RESULTS:** There were 6919 admissions with a primary or secondary diagnosis of CRC of which 27.4% were emergency admissions. The most common comorbidity was diabetes (18.5%), followed by COPD and hypertension (both 3.7%). Volume depletion disorder (3.5%) followed by pneumonia (2.4%) and malignant neoplasm of the liver (2.3%) were the most common primary diagnoses seen when CRC was the secondary diagnosis. Mean length of stay was significantly higher for admissions with a primary diagnosis (9.2 days versus 4.8 days, $p < 0.001$). Mean total charges were also higher for primary diagnosis (28,618.94 USD versus 12,195.22 USD, $p < 0.001$). For the 356 (5.1%) in-hospital deaths, emergency admissions had odds ratio (OR) of 2.50 (95% CI, 2.01–3.10), and primary diagnosis of CRC had OR of 1.64 (95% CI, 1.30–2.08). Admissions with comorbid diabetes formed 12.6% (45) of patients who died in the hospital. **CONCLUSIONS:** Significant resources are consumed by CRC hospital admissions. A large percentage of CRC hospitalizations are emergency admissions indicating advanced disease and possibly failure of timely screening. Diabetes was the most common comorbid condition and further investigation in diabetics is needed to check screening behavior and access to screening centers.

PCN155

TREATMENT PATTERN OF METASTATIC TRIPLE NEGATIVE BREAST CANCER IN COMMUNITY PRACTICE

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OBJECTIVES: Triple negative (TN) breast cancer (BC), a subtype of BC characterized by its unique molecular profile and aggressive clinical behavior, lacks satisfactory standard therapies. Little is known about how patients with TNBC were treated in community practice. This study was conducted to identify treatment patterns of first-line chemotherapy (CT) of TNBC using data from community practices. **METHODS:** Analyses were conducted using the Georgia Cancer Specialist Database (GCSD 2003–2008) and the International Oncology Network's Treatment and Outcomes Database (ION 2003–2008). In both data, patients with stage IV TNBC were selected and followed for up to one year since initial diagnosis. The first-line CT was identified if 1) the first drug was initiated within 120 days following the initial BC diagnosis; 2) other combination drugs be started within 30 days of the first drug. **RESULTS:** The study included 30 and 35 patients from GCSD and ION, respectively. In GCSD sample, 14 patients (47%) were treated with monotherapy, capecitabine and taxanes being dominant (50% and 43%, respectively); 16 patients treated with combination therapy, with carboplatin/gemcitabine+paclitaxel (C/G+P) and cyclophosphomide+doxorubicin (CP+DOX) most frequently used regimens or backbone therapies (31% for each). Other drugs used in combination included docetaxel, bevacizumab, 5-FU and albumin-bound P. Similar patterns were found in ION sample with some deviations: 20 patients (57%) treated with monotherapy, taxanes being dominant (70%); 15 patients treated with combination therapy, C/G+P and CP+DOX/+epirubicin were the most frequently used regimens or backbone therapies (33% for each). Other drugs used in combination included docetaxel, 5-FU, bevacizumab, lapatinib and methotrexate. **CONCLUSIONS:** It appears that taxanes/capecitabine, and C/G+P or CP+DOX were mostly used monotherapy and combination therapy, respectively, for stage IV TNBC. The patterns are rather diverse than convergent, reflecting lack of standard therapy for TNBC. Data from other community settings are needed to confirm these results.

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PCN156

IMPROVING ASCERTAINMENT OF VITAL STATUS USING SOCIAL SECURITY DEATH MASTER FILE (SSDMF) AND THE NATIONAL DEATH INDEX (NDI)

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BACKGROUND: Ascertainment of vital status is critical to studies in many disease areas especially in oncology. Two commonly used sources for mortality are SSDMF and NDI, with NDI considered the gold standard. Limitations identified in previous studies are under-ascertainment associated with the former; time lag (1–2 years) and higher cost associated with the latter. OBJECTIVES: To compare ascertainment of vital status by consolidating mortality data from SSDMF and NDI vs. either source alone. METHODS: Patient identifiers for a cohort of 3761 cancer patients from a large US claims database were submitted to SSDMF (cutoff February 2009) and NDI (cutoff December 2007) to obtain vital status. Matching to SSDMF utilized SSN alone or a combination of last name, first name and birthdate. Matching to NDI utilized combinations of SSN and/or patient name, birthdate, and state of residence. For patients with a death date found in NDI, a variable indicating a true or false match was provided by NDI based on the probabilistic score. We derived the death date via a stepwise approach by utilizing all match results from either source. RESULTS: Of 3761 patients, SSDMF returned a match for 901 (24%) patients using SSN alone, and 1088 (29%) patients using the combination. From the NDI, 946 (25%) patients had a "true" match, 1408 (37%) had a "false" match, and remainder were considered alive. Comparing SSDMF and NDI results utilizing both true and false NDI matches, we derived death dates for 1326 patients, which is 47% and 40% more compared to SSDMF match by SSN alone or NDI true match, respectively. Eight patients had claims following death date and were considered false matches. CONCLUSIONS: Utilizing all match results from SSDMF and NDI identified significantly more deceased patients compared to either source alone. Misclassification of living patients as deceased appears minimal as verified by claims.

PCN157

METHODOLOGIC ISSUES OF IDENTIFYING FEBRILE NEUTROPENIA PATIENTS USING MEDICAL CLAIM DATA

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Febrile neutropenia (FN) is a condition that develops in cancer patients treated with myelosuppressive chemotherapy characterized by fever and very low neutrophil counts, in general signaling infection. Utilizing claims data can provide a real-world perspective on the epidemiology, treatment, outcomes, and costs associated with FN in cancer patients. However, identifying true cases of FN in claims data can be prob-